

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044735

Facility Name: CLC Pine Lawn Manor

Address: 200 Poplar Drive Sumner 62466
Number City Zip Code

County: Lawrence

Telephone Number: (618) 936-2703 Fax # (618) 936-2517

IDPA ID Number: 770535048001

Date of Initial License for Current Owners: 04/01/00

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: Michael Kaplan Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)	
	(Type or Print Name)			
	(Title)			
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT		
		(Date)		
	(Print Name and Title)			
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606		
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518		
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630				

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLC Pine Lawn Manor

0044735 Report Period Beginning: 1/01/01 Ending: 12/31/01

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	68	Intermediate/DD	68	24,820	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	7

B. Census-For the entire report period.					
	1	2	3	4	5
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Public Aid Recipient	Private Pay	Other	Total
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	19,812	763		20,575
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	19,812	763		20,575

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.90%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 04/01/00

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number CLC Pine Lawn Manor # 0044735 Report Period Beginning: 1/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	93,705	10,767	5,400	109,872		109,872	(913)	108,959			1
2	Food Purchase		87,119		87,119		87,119	(3,194)	83,925			2
3	Housekeeping	55,164	11,081		66,245		66,245		66,245			3
4	Laundry	44,987	14,516		59,503		59,503		59,503			4
5	Heat and Other Utilities			75,919	75,919		75,919	7	75,926			5
6	Maintenance	27,489	11,297	40,004	78,790		78,790	237	79,027			6
7	Other (specify):*											7
8	TOTAL General Services	221,345	134,780	121,323	477,448		477,448	(3,863)	473,585			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	958,708	45,059	3,276	1,007,043		1,007,043		1,007,043			10
10a	Therapy	9,767	1,562	18,969	30,298		30,298		30,298			10a
11	Activities	77,400	1,803	68	79,271		79,271		79,271			11
12	Social Services	9,575		7,640	17,215		17,215		17,215			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,055,450	48,424	38,353	1,142,227		1,142,227		1,142,227			16
	C. General Administration											
17	Administrative	38,879		283,963	322,842		322,842	(283,963)	38,879			17
18	Directors Fees											18
19	Professional Services			829	829		829	12,043	12,872			19
20	Dues, Fees, Subscriptions & Promotions			7,704	7,704		7,704	1,884	9,588			20
21	Clerical & General Office Expenses	40,916	10,089	31,461	82,466		82,466	169,846	252,312			21
22	Employee Benefits & Payroll Taxes			277,552	277,552		277,552	16,997	294,549			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,856	7,856		7,856	23,502	31,358			24
25	Other Admin. Staff Transportation			923	923		923		923			25
26	Insurance-Prop.Liab.Malpractice			98,546	98,546		98,546	5,649	104,195			26
27	Other (specify):*											27
28	TOTAL General Administration	79,795	10,089	708,834	798,718		798,718	(54,042)	744,676			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,356,590	193,293	868,510	2,418,393		2,418,393	(57,905)	2,360,488			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			2,348	2,348		2,348	49,301	51,649			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,267	53,267		53,267	110,146	163,413			32
33	Real Estate Taxes			17,970	17,970		17,970	3,591	21,561			33
34	Rent-Facility & Grounds			(8,675)	(8,675)		(8,675)	13,736	5,061			34
35	Rent-Equipment & Vehicles			5,598	5,598		5,598	3,699	9,297			35
36	Other (specify):*											36
37	TOTAL Ownership			70,508	70,508		70,508	180,473	250,981			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,199		1,199		1,199		1,199			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,670	130,670		130,670		130,670			42
43	Other (specify):* Nonallowable costs			495,417	495,417		495,417	(495,417)				43
44	TOTAL Special Cost Centers		1,199	626,087	627,286		627,286	(495,417)	131,869			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,356,590	194,492	1,565,105	3,116,187		3,116,187	(372,849)	2,743,338			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,194)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(326)	20		17
18	Fines and Penalties	(143)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,345)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Sch 5A</u>	(448,136)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (487,144)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	114,295		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 114,295		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (372,849)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name CLC Pine Lawn Manor
PROVIDER # 0044735
Period Ending 12/31/01

Schedule 5A

VI. ADJUSTMENT DETAIL
 LINE 29 - Other

Description	Amount	Schedule V
		Reference
Vending Machine Offset	(913)	1
Postage Income Offset	(10)	21
Client Relations	(3,780)	43
Cable TV Expense	(1,948)	43
Marketing & Public Relations	(1,743)	43
Medicaid Workshop Expenses for DD Residents	(452,458)	43
Disallow Forgiveness of Debt	9,125	34
Real Estate Taxes adjustment	3,591	33
Total	(448,136)	

See Accountants' Compilation Report

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLC Pine Lawn Manor # 0044735 Report Period Beginning: 1/01/01 Ending: 12/31/01
 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,194)	0	0	0	0	0	0	0	0	0	0	(3,194)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	7	0	0	0	0	0	0	0	0	0	7	5
6	Maintenance	0	237	0	0	0	0	0	0	0	0	0	237	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,194)	244	0	0	0	0	0	0	0	0	0	(2,950)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(283,963)	0	0	0	0	0	0	0	0	0	(283,963)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,043	0	0	0	0	0	0	0	0	0	12,043	19
20	Fees, Subscriptions & Promotions	(326)	2,210	0	0	0	0	0	0	0	0	0	1,884	20
21	Clerical & General Office Expenses	0	169,856	0	0	0	0	0	0	0	0	0	169,856	21
22	Employee Benefits & Payroll Taxes	0	16,997	0	0	0	0	0	0	0	0	0	16,997	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	23,502	0	0	0	0	0	0	0	0	0	23,502	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	5,649	0	0	0	0	0	0	0	0	0	5,649	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(326)	(53,706)	0	0	0	0	0	0	0	0	0	(54,032)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,520)	(53,462)	0	0	0	0	0	0	0	0	0	(56,982)	29

Summary B

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Centers for Long Term Care of Illinois, Inc.	100	See Schedule 6A		Centers for Long Term Care, Inc.	Irving, TX	Healthcare Co.
				LTC-Sumner, Inc.	Oxnard, CA	Lessor
				BMW Healthcare, Inc.	Irving, TX	Healthcare Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Centers for Long Term Care, Inc.	100.00%	\$ 7	\$ 7	1
2	V	6	Maintenance Supplies		Centers for Long Term Care, Inc.	100.00%	237	237	2
3	V	17	Administrative	283,963	Centers for Long Term Care, Inc.	100.00%		(283,963)	3
4	V	19	Professional Services		Centers for Long Term Care, Inc.	100.00%	12,043	12,043	4
5	V	20	Fees, Subscriptions		Centers for Long Term Care, Inc.	100.00%	2,210	2,210	5
6	V	21	Clerical & General Office Exp		Centers for Long Term Care, Inc.	100.00%	169,856	169,856	6
7	V	22	Employee Benefits		Centers for Long Term Care, Inc.	100.00%	16,997	16,997	7
8	V	24	Travel & Seminar		Centers for Long Term Care, Inc.	100.00%	23,502	23,502	8
9	V	26	Insurance		Centers for Long Term Care, Inc.	100.00%	5,649	5,649	9
10	V	30	Depreciation		Centers for Long Term Care, Inc.	100.00%	11,001	11,001	10
11	V	34	Rent-Facility & Grounds		Centers for Long Term Care, Inc.	100.00%	4,611	4,611	11
12	V	35	Rent-Equipment & Vehicles		Centers for Long Term Care, Inc.	100.00%	3,699	3,699	12
13	V								13
14	Total			\$ 283,963			\$ 249,812	\$ * (34,151)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	\$	LTC - Sumner, Inc.	0.00%	\$ 38,300	\$ 38,300	15
16	V	32	Interest		LTC - Sumner, Inc.	0.00%	110,146	110,146	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 148,446	\$ * 148,446	39

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2	This is a publicly traded company										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LTC - Sumner, Inc.	x		Purchase of Facility	\$9,702.00	05/01/94	\$ 1,000,000	\$ 960,883	06/01/2004	0.1060	\$ 110,146	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Intercompany Interest										53,267	6	
7												7	
8												8	
9	TOTAL Facility Related				\$9,702.00		\$ 1,000,000	\$ 960,883			\$ 163,413	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,000,000	\$ 960,883			\$ 163,413	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
Under accrued in prior year

TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$12,0411

\$20,7322

\$8,6913

\$21,5614

\$5

8,6916

\$21,5617

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1996		8
1997		9
1998		10
1999	21,112	11
2000	20,732	12

2000 Real Estate Tax Bill	20,732
Est Increase	1.04
2001 Est Tax Bill	21,561

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CLC Pine Lawn Manor COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0044735

CONTACT PERSON REGARDING THIS REPORT Sheila Yukon

TELEPHONE (214) 441-9600 FAX #: (214) 441-9681

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	04-001-595-00	Nursing Facility	\$ 20,732.00	\$ 20,732.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 20,732.00	\$ 20,732.00

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,500 B. General Construction Type: Exterior Bedford Stone Frame Masonry Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (x) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (x) (a) Own the Equipment (x) (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (x) NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility			2000	\$	24,999	1
2							2
3	TOTALS				\$	24,999	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	68		2000	1977	\$ 735,000	\$	35	\$ 21,000	\$ 21,000	\$ 31,500	4
5	***		2000		(397,971)		35	(11,371)	(11,371)	(17,018)	5
6											6
7											7
8											8
	Improvement Type**										
9	***Adjust historical cost to purchase price										9
10	Original Building Improvements			1977	4,038		35	115	115	173	10
11	Original Building Improvements			1979	7,981		35	228	228	342	11
12	Original Building Improvements			1978	979		35	28	28	42	12
13	Original Building Improvements			1982	2,488		35	71	71	107	13
14	Original Building Improvements			1983	37,700		35	1,077	1,077	1,616	14
15	Original Building Improvements			1984	40,294		35	1,151	1,151	1,727	15
16	Original Building Improvements			1985	21,297		35	608	608	912	16
17	Original Building Improvements			1986	145,109		35	4,146	4,146	6,219	17
18	Original Building Improvements			1987	6,927		35	198	198	297	18
19	Original Building Improvements			1988	6,070		35	173	173	260	19
20	Original Building Improvements			1991	21,073		35	602	602	903	20
21	Original Building Improvements			1992	36,185		35	1,034	1,034	1,551	21
22	Original Building Improvements			1993	33,134		35	947	947	1,420	22
23	Reroute Emergency Circuits			1994	3,050		35	87	87	131	23
24	Mosaic Tiles			1994	540		35	15	15	23	24
25	Walk in Cooler			1994	12,600		35	360	360	540	25
26	Air Handler & Condensor			1995	4,526		35	129	129	194	26
27	Repair Roof			1995	16,750		35	479	479	718	27
28	Interior Design Consulting			1995	411		35	12	12	18	28
29	Fire Suppression System			1995	1,305		35	37	37	56	29
30	Piping for Washer			1995	1,006		35	29	29	43	30
31	Cubicle Curtains			1995	2,865		35	82	82	123	31
32	Water Heater			1995	4,865		35	139	139	209	32
33	Roof			1996	27,119		35	775	775	1,162	33
34	Install Walls, Doors, Windows			1996	753		35	22	22	33	34
35	5 Ton A/C			1997	7,504		35	214	214	321	35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Heater	1998	\$ 1,033	\$	35	\$ 30	\$ 30	\$ 45	37
38	Painting Outside Trim	1998	2,550		35	73	73	109	38
39	Sign	1998	4,488		35	128	128	192	39
40	Table Dish Built-in Sterilizer	1998	1,557		35	44	44	66	40
41	Exterior Plumbing for Drainage	1998	10,952		35	313	313	469	41
42	Sink	1998	738		35	21	21	32	42
43	Replace Guttering	1999	2,074		35	59	59	89	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 806,990	\$		\$ 23,055	\$ 23,055	\$ 34,624	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$806,990	\$		\$23,055	\$23,055	\$34,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$806,990	\$		\$23,055	\$23,055	\$34,624	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$806,990	\$		\$23,055	\$23,055	\$34,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$806,990	\$		\$23,055	\$23,055	\$34,624	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$806,990	\$		\$23,055	\$23,055	\$34,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$806,990	\$		\$23,055	\$23,055	\$34,624	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$158,816	\$1,410	\$16,655	\$15,245	3-10 yrs	\$24,540	71
72	Current Year Purchases	9,304	938	938		5-20 yrs	938	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			11,001	11,001			74
75	TOTALS	\$168,120	\$2,348	\$28,594	\$26,246		\$25,478	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,000,109	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$2,348	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$51,649	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$49,301	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$60,102	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Temporary Storage				450			5
6	Allocated from Home Office				4,611			6
7	TOTAL				\$ 5,061			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
- N/a
- N/A

9. Option to Buy:
- ☐ YES☒ NO
- Terms: N/A
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 9,297
- Description: Dishwasher \$1,438, Postage Meter \$290, Copier \$3,180, Office Eq. \$690; From Home Office \$ 3,699
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning N/A

Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$ N/A
13.	/2003	\$ N/A
14.	/2004	\$ N/A

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L. 10a C. 3	hrs	\$	5	\$ 125	\$	5	\$ 125	1
2	Licensed Speech and Language Development Therapist	L. 10a C 2, 3	hrs		48	4,116	227	48	4,343	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 2,3	hrs		242	4,376	1,335	242	5,711	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39 C. 2	# of prescripts				1,199		1,199	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Regulator&O2 Tank	L. 10a C. 3				10,352			10,352	13
14	TOTAL			\$	295	\$ 18,969	\$ 2,761	295	\$ 21,730	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$10,566	\$10,566	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance94,381)	479,323	479,323	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,629	15,629	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$505,518	\$505,518	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		24,999	13
14	Buildings, at Historical Cost	1,254	337,029	14
15	Leasehold Improvements, at Historical Cost		469,961	15
16	Equipment, at Historical Cost	14,422	168,120	16
17	Accumulated Depreciation (book methods)	(2,611)	(60,102)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$13,065	\$940,007	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$518,583	\$1,445,525	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$174,218	\$174,218	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,168	93,168	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,911	26,911	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,223	21,561	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expense	65,786	65,786	36
37	Intercompany - CLC Corp	334,881	334,881	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$721,187	\$716,525	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		960,883	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$960,883	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$721,187	\$1,677,408	46
47	TOTAL EQUITY(page 18, line 24)	\$(202,604)	\$(231,883)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$518,583	\$1,445,525	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 268,220	1
2	Restatements (describe):		2
3	Adjust Accrued Vacation	18,342	3
4	Adjust Bad Debt Allowance	(37,437)	4
5	Adjust Intercompany Account	(79,456)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 169,669	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(372,273)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (372,273)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (202,604)	24 *

Operating entity only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLC Pine Lawn Manor # 0044735 Report Period Beginning: 1/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,530,657	1
2	Discounts and Allowances for all Levels	(6,255)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,524,402	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education	215,370	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	25	13
14	Non-Patient Meals	3,194	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 218,589	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending \$ 913 & Postage \$10	923	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 923	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,743,914	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	477,448	31
32	Health Care	1,142,227	32
33	General Administration	798,718	33
	B. Capital Expense		
34	Ownership	70,508	34
	C. Ancillary Expense		
35	Special Cost Centers	496,616	35
36	Provider Participation Fee	130,670	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,116,187	40
41	Income before Income Taxes (line 30 minus line 40)**	(372,273)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (372,273)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files as part of a consolidated tax return

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,995	2,214	\$ 35,658	\$ 16.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,069	4,251	70,807	16.66	3
4	Licensed Practical Nurses	9,805	10,317	146,537	14.20	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	746	870	9,767	11.23	8
9	Activity Director	1,971	2,085	16,198	7.77	9
10	Activity Assistants	8,925	9,134	61,202	6.70	10
11	Social Service Workers	1,053	1,098	9,575	8.72	11
12	Dietician					12
13	Food Service Supervisor	2,002	2,108	20,594	9.77	13
14	Head Cook	5,170	5,452	37,786	6.93	14
15	Cook Helpers/Assistants	5,229	5,605	35,325	6.30	15
16	Dishwashers					16
17	Maintenance Workers	2,106	2,220	27,489	12.38	17
18	Housekeepers	8,166	8,445	55,164	6.53	18
19	Laundry	5,990	6,281	44,987	7.16	19
20	Administrator	2,028	2,130	38,879	18.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,976	2,215	25,505	11.51	23
24	Clerical	1,866	2,030	15,411	7.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,504	8,795	105,944	12.05	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	68,635	70,721	585,592	8.28	30
31	Medical Records	1,440	1,456	14,170	9.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,676	147,427	\$ 1,356,590 *	\$ 9.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	109	\$ 4,208	L 1, C 3	35
36	Medical Director	84	8,400	L 9, C 3	36
37	Medical Records Consultant	16	888	L 10, C 3	37
38	Nurse Consultant	47	709	L 10, C 3	38
39	Pharmacist Consultant	3	150	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	166	7,640	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	425	\$ 21,995		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name	CLC Pine Lawn Manor
PROVIDER #	0044735
Period Ending	12/31/01

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	829
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Allocated from Home Office	12,043
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Total (agree to Schedule V, line 19, column 8)	<u>12,872</u>
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See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLC Pine Lawn Manor

0044735

Report Period Beginning:

1/01/01

Ending:

12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$ 3,110
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 11.6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 363 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 130,670
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,194
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation. Trips to Home Office in Texas
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit has not been completed,
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	93,705	10,767	5,400	109,872	0	109,872	-913	108,959
2. Food Purchase	0	87,119	0	87,119	0	87,119	-3,194	83,925
3. Housekeeping	55,164	11,081	0	66,245	0	66,245	0	66,245
4. Laundry	44,987	14,516	0	59,503	0	59,503	0	59,503
5. Heat and Other Utilities	0	0	75,919	75,919	0	75,919	7	75,926
6. Maintenance	27,489	11,297	40,004	78,790	0	78,790	237	79,027
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	221,345	134,780	121,323	477,448	0	477,448	-3,863	473,585
9. Medical Director	0	0	8,400	8,400	0	8,400	0	8,400
10. Nursing & Medical Records	958,708	45,059	3,276	1,007,043	0	1,007,043	0	1,007,043
10a. Therapy	9,767	1,562	18,969	30,298	0	30,298	0	30,298
11. Activities	77,400	1,803	68	79,271	0	79,271	0	79,271
12. Social Services	9,575	0	7,640	17,215	0	17,215	0	17,215
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,055,450	48,424	38,353	1,142,227	0	1,142,227	0	1,142,227
17. Administrative	38,879	0	283,963	322,842	0	322,842	-283,963	38,879
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	829	829	0	829	12,043	12,872
20. Fees, Subscriptions & Promotion	0	0	7,704	7,704	0	7,704	1,884	9,588
21. Clerical & General Office	40,916	10,089	31,461	82,466	0	82,466	169,846	252,312
22. Employee Benefits & Payroll	0	0	277,552	277,552	0	277,552	16,997	294,549
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	7,856	7,856	0	7,856	23,502	31,358
25. Other Admin. Staff Trans	0	0	923	923	0	923	0	923
26. Insurance-Prop.Liab.Malpractice	0	0	98,546	98,546	0	98,546	5,649	104,195
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	79,795	10,089	708,834	798,718	0	798,718	-54,042	744,676
29. Total General Administrative	1,356,590	193,293	868,510	2,418,393	0	2,418,393	-57,905	2,360,488
30. Depreciation	0	0	2,348	2,348	0	2,348	49,301	51,649
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	53,267	53,267	0	53,267	110,146	163,413
33. Real Estate	0	0	17,970	17,970	0	17,970	3,591	21,561
34. Rent - Facility & Grounds	0	0	-8,675	-8,675	0	-8,675	13,736	5,061
35. Rent - Equipment & Vehicles	0	0	5,598	5,598	0	5,598	3,699	9,297
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	70,508	70,508	0	70,508	180,473	250,981
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	1,199	0	1,199	0	1,199	0	1,199
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	130,670	130,670	0	130,670	0	130,670
43. Other (specify):*	0	0	495,417	495,417	0	495,417	-495,417	0
44. Total Special Cost Ce	0	1,199	626,087	627,286	0	627,286	-495,417	131,869
45. Grand Total	1,356,590	194,492	1,565,105	3,116,187	0	3,116,187	-372,849	2,743,338

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	10,566	10,566
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	479,323	479,323
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	15,629	15,629
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	505,518	505,518
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	24,999
14. Buildings, at Historical Cost	1,254	337,029
15. Leasehold Improvements, Historical Cost	0	469,961
16. Equipment, at Historical Cost	14,422	168,120
17. Accumulated Depreciation (book methods)	-2,611	-60,102
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	13,065	940,007
25. Total Assets	518,583	1,445,525
CURRENT LIABILITIES		
26. Accounts Payable	174,218	174,218
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	93,168	93,168
31. Accrued Taxes Payable	26,911	26,911
32. Accrued Real Estate Taxes	26,223	21,561
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	65,786	65,786
37. Other Current Liabilities (specify):	334,881	334,881
38. Total Current Liabilities	721,187	716,525
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	960,883
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	960,883
46.Total Liabilities	721,187	1,677,408
47.Total Equity	-202,604	-231,883
48.Total Liabilities and Equity	518,583	1,445,525

	Balance per
	Medicaid
	Trial Balance
1. Gross Revenue - All levels of Care	2,530,657
2. Discounts and Allowances for all Levels	-6,255
Subtotal - Inpatient Care	2,524,402
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	0
9. Payments for Education	215,370
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	25
14. Non-Patient Meals	3,194
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	218,589
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	923
28. Other Revenue (specify):	0
Subtotal - Other Revenue	923
30. Total Revenue	2,743,914
31. General Services	477,448
32. Health Care	1,142,227
33. General Administration	798,718
34. Ownership	70,508
35. Special Cost Centers	496,616
35. Provider Participation Fee	130,670
37. Other	0
40. Total Expenses	3,116,187
41. Income Before Income Taxes	-372,273
42. Income Taxes	0
43. Net Income or Loss for the Year	-372,273

Page

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10 Attachment of Real Estate Bill and fill out form

11

12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under **, you must write in any comments

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21

22

23

RECONCILIATION REPORT				CLC Pine Lawn Manor				02:21 PM		11/07/05					
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.		
Adjustment Detail	-372,849	equal to	-372,849	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7		
Interest Expense	163,413	equal to	163,413	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8		
Real Estate Tax Expenses	21,561	equal to	21,561	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8		
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8		
Ownership Costs-Depreciation	51,649	equal to	51,649	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8		
Rental Costs A	5,061	equal to	5,061	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8		
Rental Costs B	9,297	equal to	9,297	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8		
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8		
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1		
Therapy Services	10,179	equal to	30,298	-20,119	FAILED	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4		
Special Serv.- Supplies	2,761	equal to	2,761	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2		
Income Stat. General Serv.	477,448	equal to	477,448	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4		
Income Stat. Health Care	1,142,227	equal to	1,142,227	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4		
Income Stat. Admininstration	798,718	equal to	798,718	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4		
Income Stat. Ownership	70,508	equal to	70,508	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4		
Income Stat. Special Cost Ctr	496,616	equal to	496,616	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38to41+43	4		
Income Stat. Prov. Partic.	130,670	equal to	130,670	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4		
Staff- Nursing	958,708	equal to	958,708	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1		
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1		
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1		
Staff- Activities	77,400	equal to	77,400	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1		
Staff- Social Serv. Workers	9,575	equal to	9,575	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1		
Staff- Dietary	93,705	equal to	93,705	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1		
Staff- Maintenance	27,489	equal to	27,489	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1		
Staff- Housekeeping	55,164	equal to	55,164	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1		
Staff- Laundry	44,987	equal to	44,987	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1		
Staff- Administrative	38,879	equal to	38,879	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1		
Staff- Clerical	40,916	equal to	40,916	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1		
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1		
Total Salaries And Wages	1,356,590	equal to	1,356,590	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1		
Dietary Consultant	4,208	< or = to	5,400	-1,192	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3		
Medical Director	8,400	< or = to	8,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3		
Consultants & contractors	1,747	< or = to	3,276	-1,529	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3		
Activity Consultant	0	< or = to	68	-68	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3		
Social Service Consultant	7,640	< or = to	7,640	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3		
Supp. Sched.- Admin. Salar.	38,879	equal to	38,879	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1		
Supp. Sched.- Admin. Other	283,963	equal to	283,963	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3		
Supp. Sched.- Prof. Serv.	829	equal to	829	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3		
Supp. Sched.- Benefit/Taxes	294,549	equal to	294,549	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8		
Supp. Sched.- Sched of dues..	9,588	equal to	9,588	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8		
Supp. Sched.- Sched. of trav	31,358	equal to	31,358	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8		
Gen. Info - Particip. Fees	130,670	equal to	130,670	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3		
Gen. Info - Employee Meals	0	< or = to	16,997	-16,997	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7		
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A		
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1		
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4		
Adjustment for related org. costs	114,295	equal to	114,295	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8		
Total loan balance	960,883	equal to	960,883	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2		
Real estate tax accrual	21,561	equal to	21,561	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2		
Land	24,999	equal to	24,999	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2		
Building cost	806,990	equal to	806,990	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2		
Equipment and vehicle cost	168,120	equal to	168,120	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2		
Accumulated depr.	60,102	equal to	60,102	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2		
End of year equity	-202,604	equal to	-202,604	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1		
Net income (loss)	-372,273	equal to	-372,273	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2		
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2		
Balance Sheet	518,583	equal to	518,583	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1		